KENTUCKY BOARD OF LICENSURE FOR MARRIAGE AND FAMILY THERAPISTS

P.O. Box 1360, Frankfort, Kentucky 40601 ~ 911 Leawood Drive, Frankfort, Kentucky 40601
Phone (502) 564-3296, Fax (502) 696-5849 ~ http://mft.ky.gov

PLAN OF SUPERVISION FOR CLINCIAL EXPERIENCE

Last Name | First Name | Middle I. | Assoc. Permit #

Street Address | City | State | Zip Code

Email Address | Phone Number

PRIMARY CLINCIAL MARRIAGE & FAMILY THERAPY SETTING

Agency Name | Phone Number

Street Address | City | State | Zip Code

Description of agency function (hospital, mental health agency, private practice, etc.

Beginning Date of Plan: _____ Estimated Ending Date: _____

ADDITIONAL CLINICAL MARRAGE & FAMILY THERAPY SETTING

Agency Name | Phone Number

Street Address | City | State | Zip Code

Description of agency function (hospital, mental health agency, private practice, etc.

Beginning Date of Plan: _____ Estimated Ending Date: _____

BOARD APPROVED SUPERVISOR

Name | KY LMFT License #

Street Address | City | State | Zip Code

Home Phone Number | Work Phone Number

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PLAN OF MARRIAGE AND FAMILY THERAPY SUPERVISION*

A. A detailed description of the nature of this work setting is (i.e. what types of activities, therapies, counseling, etc: will they be individuals, couples, groups, etc; length and duration of therapy.)

B. A detailed description of the nature, duration, and frequency of supervision in the practice is: (i.e. how often and how long are supervisory sessions; what will be done in supervisory sessions; how will they be conducted)

C. A detailed description of the condition or procedures for termination of this relationship is:

D. Hours per week spent in direct client-professional relationship (Include diagnosis and treatment only)

***Pursuant to 201 KAR 32:035. Supervision of marriage and family therapist associates.**
Section 3. Clinical Supervision.

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SUPERVISOR'S STATEMENT

I, the supervisor for the above named candidate for licensure for the independent practice of marriage and family therapy, have devised and discussed this plan with said applicant and accept responsibility for its implementation. Further, I understand that upon completion of the plan of supervision for marriage and family therapy experience and application for examination, I will be asked to comment on the ethical behavior and therapeutic competency acquired by the applicant. If, for any reason, the conditions of this plan are changed, or this supervisory relationship is terminated or changed, I will immediately notify the Board. Further, I do hereby certify that my license is current, and will be maintained throughout this period.

Signature of Board Approved Supervisor: _____ Date: _____

APPLICANT STATEMENT

I, the applicant in the above plan, understand that pursuant to 201 KAR 32:025, Section 2, I will be expected to comply with the provisions in this plan in its entirety and must notify the Board of any modifications of this plan once it has been approved by it. Failure to do so may result in voiding the approval given by the Board and loss of supervision hours gained.

Signature of Applicant: _____ Date: _____

ADMINISTRATIVE SUPERVISOR STATEMENT

If the supervision in the Plan of Marriage and Family Therapy Supervision in this application is provided by someone other than the applicant's agency supervisor, the agency supervisor must review the proposed plan and sign the statement below.

As agency supervisor of the above named candidate, I affirm the agency will support the proposed practice experience as described.

Signature of Agency Supervisor: _____ Date: _____

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STATEMENT OF SHARED RESPONSIBILITY

If the supervision of the for the activities listed in this application is to be received outside the applicant's place of employment, the section below must be completed and signed by the Board Approved Supervisor, the applicant, and an authorized person representing the agency.

We the undersigned, do hereby acknowledge the sharing of professional responsibility between _____ and _____
(name of agency) (board approved supervisor)
for the clinical MFT service provided to clients of the above named agency by _____
(applicant)
and are jointly to be held accountable for the quality of the service provided. We further acknowledge that since the supervision outlined previously will take place outside the agency of employment and that the agency cases will be used in this supervisory relationship, complete and total confidentiality of patient records will be maintained by all parties throughout the period.

Signature of Board Approved Supervisor License Number Date

Signature of Applicant Date

Signature of Agency Representative Date